



Disability Retirement Election Application

888 CalPERS (or 888-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240

Employer Information

☐ Check if this is an employer-originated application.

Employer must fill out and sign Section 12 on the last page of this application.

Application Type

☐ Disability Retirement

☐ Service Pending Disability Retirement

☐ Industrial Disability Retirement

☐ Service Pending Industrial Disability Retirement

Section 1

Please provide your name as it appears on the Social Security card.

Please display all dates in this order: month/day/year.

Information About You

Name of Member (First Name, Middle Initial, Last Name) Social Security Number

Address

City State ZIP Country

Birth Date (mm/dd/yyyy) Gender ☐ Male ☐ Female Home Phone Work Phone

Section 2

Please do not abbreviate your employer or position.

Do not list Social Security, military or railroad retirement as a California public retirement system.

Retirement Information

Retirement Date (mm/dd/yyyy)

Employer Position Title

Do you have any final compensation period higher than the last consecutive 12 or 36 months?

☐ No ☐ Yes, from Beginning Date (mm/dd/yyyy) to Ending Date (mm/dd/yyyy)

Are you a member of a California public retirement system other than CalPERS? ☐ No ☐ Yes, provide:

Name of System

Date of Retirement (mm/dd/yyyy) Beginning Service Credit Date (mm/dd/yyyy) Ending Service Credit Date (mm/dd/yyyy)

Section 3

Local safety members should not complete Sections 3 & 4.

Workers' Compensation Information

Workers' Compensation Carrier

Name of Adjuster Phone Number

Address

City State ZIP

Claim Number(s) Relating to Alleged Disability Date of Injury (mm/dd/yyyy)

Put your name and
Social Security number
at the top of every page.

Your Name

____ - ____ - ____
Social Security Number

Section 4

Please complete all the
questions below. If you
need additional space,
attach separate sheets
and be sure to include your
name and Social Security
number on all sheets.

Disability Information

What is your specific disability; when and how did it occur?

What is the complete name and address of your treating physician(s)?

Name of Treating Physician

Medical Record Number

Address

City

State

ZIP

____ (____) ____
Phone Number

What are your limitations/preclusions due to your injury or illness?

How has your injury or illness affected your ability to perform your job?

Are you currently working in any capacity (full-time, part-time, or modified work)? If yes, please explain.

Other information you would like to provide.

Did a third party cause your injury? ☐ No ☐ Yes (If yes, CalPERS has a potential "right of subrogation.")

Section 5

Select only one payment
option: Option 1, Option 2,
Option 2W, Option 3,
Option 3W, the Unmodified
Allowance Option, or one of
the Option 4 types.

These options apply
to Option 4 **Individual
Lifetime Beneficiary** only.

This option applies to
Option 4 **Multiple Lifetime
Beneficiaries** only.

These options apply to
Option 4, **Court Ordered
Community Property** only.

Select Your Retirement Payment Option and Beneficiary

By filling out this section, you are electing your Retirement Payment Option and designating your beneficiary. Once you select a payment option, you cannot change to another option. Along with your option selection, you must complete at least one of the beneficiary designations in Sections 5a-5d. If you choose the Unmodified Allowance Option, you do not need to specify a beneficiary. Please refer to the detailed instructions in this publication for more information.

- ☐ **Option 1** - To complete this option choice, you must also fill out Section 5d, *Balance of Contributions Beneficiary(ies)*.
- ☐ **Option 2** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.
- ☐ **Option 2W** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.
- ☐ **Option 3** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.
- ☐ **Option 3W** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.
- ☐ **Unmodified Allowance Option** - If you select this option there is no return of your member contributions and no monthly benefits payable upon your death - except the Survivor Continuance benefit, if applicable. There is no beneficiary designation for this option.
-
- ☐ **Option 4, Individual Lifetime Beneficiary** - If you select this option, you must also select one of the following Individual Lifetime Beneficiary options below.
- ☐ **Option 2W & Option 1 Combined** - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary* and Section 5d *Balance of Contributions Beneficiary(ies)*.
- ☐ **Option 3W & Option 1 Combined** - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary* and Section 5d *Balance of Contributions Beneficiary(ies)*.
- ☐ **Specific Dollar Amount to Beneficiary** \$ _____ - To complete this option choice, you must also fill out
Section 5a *Individual Lifetime Beneficiary* Dollars
- ☐ **Specific Percentage to Beneficiary** _____ % - To complete this option choice, you must also fill out
Section 5a *Individual Lifetime Beneficiary* Percent
- ☐ **Reduced Allowance for Fixed Period of Time** _____ through _____ .
Percent or Dollars Date (mm/yyyy)
- ☐ **Reduced Allowance upon death of retiree or beneficiary:** \$ _____ reduction amount
Dollars
- If you are naming a beneficiary under this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.

-
- ☐ **Option 4, Multiple Lifetime Beneficiaries** - To complete this option choice, you must also fill out Section 5b *Option 4 Multiple Lifetime Beneficiaries*.

-
- ☐ **Option 4, Court Ordered Community Property** - If you select this option, you must also complete Section 5c, *Court Ordered C.P. Beneficiary* and select one of the following Court Ordered Option 4 Community Property options.

- ☐ **Option 4/Unmodified** - There is no additional beneficiary designation for this option.
- ☐ **Option 4/1** - To complete this option choice, you must also fill out Section 5d, *Balance of Contributions Beneficiary(ies)*.
- ☐ **Option 4/2W** - To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.
- ☐ **Option 4/3W** - To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.

Put your name and
Social Security number
at the top of every page.

Your Name

Social Security Number

Section 5a

Designate one beneficiary
and provide all of that
person's information
including full name.

Option 2, 2W, 3, 3W or 4 Individual Lifetime Beneficiary

Complete this section only if you chose either Option 2, 2W, 3, 3W or Option 4 Individual Lifetime Beneficiary or Option 4/2W or 4/3W Court Ordered Community Property.

Name (First Name, Middle Initial, Last Name)		Social Security Number	
Birth Date (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to You	
Address			
City	State	ZIP	Country

Section 5b

If you want your
beneficiaries to receive
an equal share of your
benefits, do not specify
a dollar or percentage
of benefit.

Option 4 Multiple Lifetime Beneficiaries

Complete this section only if you selected Option 4 Multiple Lifetime Beneficiaries.

Name (First Name, Middle Initial, Last Name)		Social Security Number	
Birth Date (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to You	Dollar/Percent of Benefit
Address			
City	State	ZIP	Country

Name (First Name, Middle Initial, Last Name)		Social Security Number	
Birth Date (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to You	Dollar/Percent of Benefit
Address			
City	State	ZIP	Country

Name (First Name, Middle Initial, Last Name)		Social Security Number	
Birth Date (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to You	Dollar/Percent of Benefit
Address			
City	State	ZIP	Country

Section 5c

List only the
Option 4 beneficiary
that is required by your
court order.

Court Ordered Option 4 Community Property Beneficiary

Complete this section only if you selected Option 4 Court Ordered Community Property.

Name (First Name, Middle Initial, Last Name)		Social Security Number	
Birth Date (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to You	
Address			
City	State	ZIP	Country

Put your name and
Social Security number
at the top of every page.

Your Name

Social Security Number

Section 5d

Designate up to
three beneficiaries
here. If you want to
designate more than
three beneficiaries. See
page 23 for information
on completing the
**Lump Sum Beneficiary
Designation** form.

Option 1 Balance of Contributions Beneficiary(ies)

Complete this section only if you selected **Option 1, Option 4-2W/1 or 3W/1 combined**. You may change this beneficiary(ies) at any time. This designation automatically revokes when there is a change in your marital status, domestic partnership status, or when there is a birth or adoption of a child. Please refer to the detailed instructions in this publication for more information.

Name (First Name, Middle Initial, Last Name)		Social Security Number	
Birth Date (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to You	
Address			
City	State	ZIP	Country

Name (First Name, Middle Initial, Last Name)		Social Security Number	
Birth Date (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to You	
Address			
City	State	ZIP	Country

Name (First Name, Middle Initial, Last Name)		Social Security Number	
Birth Date (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to You	
Address			
City	State	ZIP	Country

Section 6

All Applicants must
complete this section.

Designate your beneficiary
to receive your lump sum
Retired Death Benefit.

Retired Death Benefit

This section designates the person who will receive your lump sum Retired Death Benefit. You may change this beneficiary(ies) at any time. This designation automatically revokes when there is a change in your marital status, domestic partnership status, or when there is a birth or adoption of a child. Please refer to the detailed instructions in this publication for more information.

Name (First Name, Middle Initial, Last Name)		Social Security Number	
Birth Date (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to You	
Address			
City	State	ZIP	Country

Section 6 continues on page 6

Put your name and
Social Security number
at the top of every page.

Section 6, continued

All Applicants must
complete this section.

Designate your beneficiary
to receive your lump sum
Retired Death Benefit.

Your Name

Social Security Number

Retired Death Benefit

Name (First Name, Middle Initial, Last Name)

Social Security Number

Birth Date (mm/dd/yyyy)

☐ Male ☐ Female
Gender

Relationship to You

Address

City

State

ZIP

Country

Name (First Name, Middle Initial, Last Name)

Social Security Number

Birthdate (mm/dd/yyyy)

☐ Male ☐ Female
Gender

Relationship to You

Address

City

State

ZIP

Country

Section 7

Please answer
all five questions and
complete the information
in each section where you
answered "Yes."

Survivor Continuance

Please refer to the detailed instructions in this publication for more information.

1. Will you be married on or before your disability retirement date? ☐ No ☐ Yes, provide:

Name of Spouse (First Name, Middle Initial, Last Name)

Social Security Number

Birth Date (mm/dd/yyyy)

☐ Male ☐ Female
Gender

Date of Marriage

2. Will you be registered with the California Secretary of State as being in a domestic partnership on or before your disability retirement date? ☐ No ☐ Yes, provide:

Name of Domestic Partner (First Name, Middle Initial, Last Name)

Social Security Number

Birth Date (mm/dd/yyyy)

☐ Male ☐ Female
Gender

Date of Registered Partnership (mm/dd/yyyy)

3. Do you have any natural or adopted children under age 18 who have never been married?
☐ No ☐ Yes, provide:

Name of Child (First Name, Middle Initial, Last Name)

Social Security Number

Birth Date (mm/dd/yyyy)

Name of Child (First Name, Middle Initial, Last Name)

Social Security Number

Birth Date (mm/dd/yyyy)

4. Do you have any children who have never been married and were disabled prior to their 18th birthday and who are still disabled? ☐ No ☐ Yes, provide:

Name of Child (First Name, Middle Initial, Last Name)

Social Security Number

Birth Date (mm/dd/yyyy)

Name of Child (First Name, Middle Initial, Last Name)

Social Security Number

Birth Date (mm/dd/yyyy)

5. Are your parents dependent upon you for one-half of their support? ☐ No ☐ Yes, provide:

Name of Parent (First Name, Middle Initial, Last Name)

Social Security Number

Birth Date (mm/dd/yyyy)

Name of Parent (First Name, Middle Initial, Last Name)

Social Security Number

Birth Date (mm/dd/yyyy)

Put your name and
Social Security number
at the top of every page.

Your Name

Social Security Number

Section 8

Last Day on Payroll

Please enter the last day you received compensation. _____
Last Day on Payroll (mm/dd/yyyy)

Section 9

Employer Certification (For service pending applications only)

Have your employer
complete this section.

Please refer to the detailed instructions in this publication for more information.

**Do not detach from
application.**

This certification is
not required if you
were separated from
employment more than
four months ago.

Employee's Last Day on Payroll (mm/dd/yyyy)

Employee's Separation Date (mm/dd/yyyy)

Balance of unused sick leave hours on employee's date of separation _____ ÷ 8 = _____
Hours Days

Balance of educational leave hours on employee's date of separation _____ ÷ 8 = _____
Hours Days

By signing below, you hereby certify, under the penalty of perjury, that the above information is true, complete, and correct to the best of your knowledge. Any changes to this information must be submitted on an **Amended Employer Certification** form.

Signature of Employer

Print Name (First Name, Middle Initial, Last Name)

Position Title of Employer

()
Phone Number of Employer

Date (mm/dd/yyyy)

Section 10

Tax Withholding Election

**Do not complete for
industrial disability
retirement.**

Federal Income Tax information. Please refer to the detailed instructions in this publication for more information.

Please choose one only.

- ☐ Do not withhold federal income tax.
- ☐ Withhold federal income tax in the amount of \$ _____ per month.
Dollars
- ☐ Withhold federal income tax based on the tax tables for:
- ☐ **A married individual with _____ tax withholding exemptions.**
Number
- ☐ **A single individual with _____ tax withholding exemptions.**
Number

In addition to the amount withheld based on the tax tables, withhold \$ _____ per month.
Dollars

State withholding
is optional for
out-of-state residents.

State Income Tax information. Please refer to the detailed instructions in this publication for more information.

- ☐ Do not withhold State of California income tax.
- ☐ Withhold State of California income tax in the amount of \$ _____ per month.
Dollars
- ☐ Withhold State of California income tax based on the tax tables for:
- ☐ **A married individual with _____ tax withholding exemptions.**
Number
- ☐ **A single individual with _____ tax withholding exemptions.**
Number
- In addition to the amount withheld based on the tax tables, withhold \$ _____ per month.
Dollars
- ☐ Withhold State of California income tax in the amount of 10 percent of the federal income tax withholding amount.

Your Name

Social Security Number

Section 11

This section must
be completed or
your application will
be returned.

If your spouse's or
domestic partner's
signature is not available,
See instructions in this
booklet on completing the
Justification for Absence
of Signature form.
Your signature and your
spouse's or domestic
partner's signature must
be notarized by a notary
public or witnessed by a
CalPERS representative.

Member Signature and Notary

I certify, under the penalty of perjury, that the information submitted hereon is true and correct to the best of my knowledge. I understand to cancel this application or to change the elected option or beneficiary I must notify CalPERS before the mailing of my first full monthly retirement allowance check.

I understand that if I am married or in a registered domestic partnership, but do not name my spouse or partner as beneficiary, they may still be entitled to a community property share of the Option 1 lump sum return of contributions benefit **or** a share of the monthly option death benefit allowance. Their community property interest is 50% of the benefit based on the contributions or service credit earned for the period of CalPERS service during which we were married or in a registered partnership. My non-spouse or non-partner designated beneficiary will receive the portion of the lump sum Option 1 benefit or monthly option allowance that is not payable to my spouse or domestic partner. I understand that my spouse or domestic partner will have the right to disclaim entitlement to their community property interest in the death benefit at the time the benefit becomes payable, if they so desire.

More detailed information on this section is available in this publication.

Are you legally married or do you have a legal domestic partner? ☐ Yes ☐ No

If yes, your spouse or domestic partner must sign this election.

If no, please indicate: ☐ Never Married/or in Partnership ☐ Divorced/Annulled
☐ Widowed Or Termination of Domestic Partnership

Your Signature

Date (mm/dd/yyyy)

Your Spouse's or Domestic Partner's Signature

Date (mm/dd/yyyy)

State of California, County of _____

On _____ before me, _____
Date Name of Notary/Witness

personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument. I certify under **Penalty of Perjury** under the laws of the State of California that the foregoing paragraph is true and correct.

Notary Seal

Witness my hand and official seal **or** authorized CalPERS representative signature.

Signature of Notary or CalPERS Representative

Position Title

Date (mm/dd/yyyy)

Print Name

CalPERS Office (if applicable)

Section 12

To be completed if the
employer is submitting
the application on behalf
of the member.

Employer-Originated Application

Signature of Employer

Print Name of Employer

Position Title of Employer

()
Phone Number

Date (mm/dd/yyyy)

Mail to:

CalPERS Benefit Services Division • P.O. Box 942711, Sacramento, California 94229-2711